EXPLANATORY NOTES TO BASIC GUIDELINES FOR DIABETES CARE

1. These guidelines are intended for use by primary care professionals.
2. The guidelines are meant to be basic **guidelines,** not enforceable standards.

(Where an internal quality assurance program has demonstrated that less frequent testing does not jeopardize patient care, less frequent testing may be acceptable; e.g., dilated eye exams every two years vs. every year.)

3. One or more of the following criteria were used for inclusion of an item in the guidelines:
    a. Published evidence demonstrated either the **efficacy** or the **effectiveness** of the item.
    b. Published studies on **cost-identification**, **cost-effectiveness**, or **cost-benefit** analysis of the item demonstrated favorable economic results.
    c. A preponderance of **expert opinion** held that the item is considered to be essential to the care of persons with diabetes.
4. It is assumed that the following are routinely occurring in the medical setting:
    a. A history and physical appropriate for a person with diabetes are performed. Visits are sufficiently frequent to meet the patient's needs and treatment goals.
    b. Abnormal physical or laboratory findings result in appropriate interventions which are individualized for each patient.
    c. Self-Management Training is provided by allied health professionals who are experts in the provision of this training. For children/adolescents and their families, training from a diabetes team or team member with experience in child and adolescent diabetes is strongly recommended to begin at diagnosis.
    d. Physicians consult current references for normal values and for appropriate treatment goal values, both for children and adults.
    e. Specialists should be consulted when patients are unable to achieve treatment goals in a reasonable time frame, when complications arise, or whenever the primary care physician deems it appropriate. Under similar circumstances, children/adolescents should be referred to specialists who have expertise in managing children and adolescents with diabetes.
5. Additional comments on specific items included in the guidelines:

Children / Adolescents – For specific diabetes care, see references.

HbA1c / Self Blood Glucose Monitoring – HbA1c target goals should be achieved gradually over time. Target goals should be less stringent for children, the elderly and other fragile patients. Clinicians have found that making the patient aware of his/her HbA1c values and their significance helps motivate the patient toward improved glucose management. This principle also applies to self blood glucose monitoring. **Target goals should be individualized for each patient.**

Blood Lipids – Abnormal blood lipids are often under-treated. An active, progressive treatment and monitoring plan should be instituted. The clinical judgement of the physician should be relied upon in determining the goal when the patient without evidence of CHD has an LDL between 100 and 129 or the non-HDL cholesterol is between 130 and 160.

Microalbuminuria – Need not test for microalbuminuria if albumin has previously been found in the urine.

Psychosocial assessment – Barriers to self-care—common environmental obstacles, cultural issues, beliefs and feelings about diabetes, disorders of eating and mood, and life stresses and substance use.

6. A list of general and specific references is available.